

9514

CERTIFICATE OF DEATH

Reg. Dist. No.

09488

1. PLACE OF DEATH o. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) o. STATE <u>MARY</u> o. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grasonville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>E</u> Middle <u>Bouldin</u> Last				4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/3/75</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>MARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Rachael Hazelton, Grasonville, Md.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>James Bouldin, Grasonville, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>? yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u>19</u> p. m. <u> </u>	Month <u> </u> Day <u> </u> Year <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>57</u> , to <u>Aug.</u> , 19 <u>59</u> that I last saw the deceased alive on <u>Aug 19</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Grasonville, Md.</u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u> M.D.		PHYSICIAN'S NAME (Type) <u>Irvin G. Hoyt MD</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/22/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grasonville Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Grasonville, Md.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Bouldin, Grasonville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Clinical Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

9515

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09489

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>		c. LENGTH OF STAY IN TB <u>53 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stevensville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>Rural</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Thomas</u> Middle <u>Franklin</u> Last <u>Gardner</u>				4. DATE OF DEATH Month <u>Aug</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19 1905</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sea Food</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Edward Gardner</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Louise King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Nettie Gardner</u>		Address <u>Stevensville</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Irvin B. Hoyt</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Irvin B. Hoyt MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9/27/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>AUG 29</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE</u>		22d. LOCATION (City, town, or county) (State) <u>STEVENSVILLE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Kane - Church Hill, Md.</u>				24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>	
SEX <i>Male</i>		RACE <i>White</i>	
DATE OF DEATH <i>Jan 15 1920</i>		PLACE OF DEATH <i>Home</i>	
RESIDENCE <i>123 Main St. Baltimore, Md.</i>		OCCUPATION <i>Teacher</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF EXAMINER <i>J. H. Smith</i>		DATE <i>Jan 15 1920</i>	
LOCAL HEALTH OFFICER <i>W. B. Jones</i>		COUNTY CLERK <i>John Doe</i>	
MAYOR <i>John Doe</i>		COMMISSIONER OF HEALTH <i>John Doe</i>	

1

1

9517

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09491

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Q A</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henderson Md</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Henderson Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Charles Downs Farm</u>				d. STREET ADDRESS <u>RF D-1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Clayton Lister</u> First Middle Last				4. DATE OF DEATH Month <u>Aug</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 29, 1906</u>		9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Georgetown Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence W Lister</u>				14. MOTHER'S MAIDEN NAME <u>Addie Tribbitt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Addie Tribbitt</u> Address <u>Denton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 hr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>No</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>C. R. Layton</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>C. R. Layton</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>Aug 9, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro Md</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Bouclair</u>				ADDRESS <u>Greensboro Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 11 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Christina S. Knaus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9517

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
John Doe		Male		45		Jan 1, 1900		New York City		Teacher	
RESIDENCE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY	
123 Main St, Boston		Jan 15, 1945		Home		Heart Disease		Natural		None	
PREVIOUS ILLNESS		DATE OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER		STAMP	
None		Jan 15, 1945		Home		[Signature]		Physician		[Stamp]	
FAMILY HISTORY		DATE OF BURIAL		PLACE OF BURIAL		SIGNATURE OF FUNERAL HOME		TITLE OF FUNERAL HOME		STAMP	
None		Jan 18, 1945		Cemetery		[Signature]		Funeral Home		[Stamp]	
TESTIMONY OF WITNESSES		DATE OF INTERVIEW		PLACE OF INTERVIEW		SIGNATURE OF INTERVIEWER		TITLE OF INTERVIEWER		STAMP	
None		Jan 15, 1945		Home		[Signature]		Physician		[Stamp]	

1

**FOR STATE
HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CHARLES EDWARD LUCKE, JR.</u>		4. DATE OF DEATH <u>August 6</u> 19 <u>59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>March 18 - 1905</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hocking Magazine</u>	
11. BIRTHPLACE (State or foreign country) <u>New York N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Lucke</u>		14. MOTHER'S MAIDEN NAME <u>Ira Becker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW I WW II</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Thomas Mervin Lucke</u>		Address <u>15 Allan Village</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Alcoholism</u> 322.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Irvin G. Hoyt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>IRVIN G. HOYT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>Aug 10 - 59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Seabrook</u>		22d. LOCATION (City, town, or county) (State) <u>Wilmington Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Evans Bunting</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>	
ADDRESS <u>Baltimore, Md</u>		DATE <u>AUG 10 '59</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 1. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Medical History: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

11. Signature of Physician: _____

12. Signature of Nurse: _____

13. Signature of Pathologist: _____

14. Signature of Forensic Scientist: _____

15. Signature of Toxicologist: _____

16. Signature of Radiologist: _____

17. Signature of Psychiatrist: _____

18. Signature of Social Worker: _____

19. Signature of Chaplain: _____

20. Signature of Funeral Home: _____

21. Signature of Cemetery: _____

22. Signature of Burial: _____

23. Signature of Interment: _____

24. Signature of Final Disposition: _____

25. Signature of Final Resting Place: _____

26. Signature of Final Disposition: _____

27. Signature of Final Resting Place: _____

28. Signature of Final Disposition: _____

29. Signature of Final Resting Place: _____

30. Signature of Final Disposition: _____

31. Signature of Final Resting Place: _____

32. Signature of Final Disposition: _____

33. Signature of Final Resting Place: _____

34. Signature of Final Disposition: _____

35. Signature of Final Resting Place: _____

36. Signature of Final Disposition: _____

37. Signature of Final Resting Place: _____

38. Signature of Final Disposition: _____

39. Signature of Final Resting Place: _____

40. Signature of Final Disposition: _____

41. Signature of Final Resting Place: _____

42. Signature of Final Disposition: _____

43. Signature of Final Resting Place: _____

44. Signature of Final Disposition: _____

45. Signature of Final Resting Place: _____

46. Signature of Final Disposition: _____

47. Signature of Final Resting Place: _____

48. Signature of Final Disposition: _____

49. Signature of Final Resting Place: _____

50. Signature of Final Disposition: _____

51. Signature of Final Resting Place: _____

52. Signature of Final Disposition: _____

53. Signature of Final Resting Place: _____

54. Signature of Final Disposition: _____

55. Signature of Final Resting Place: _____

56. Signature of Final Disposition: _____

57. Signature of Final Resting Place: _____

58. Signature of Final Disposition: _____

59. Signature of Final Resting Place: _____

60. Signature of Final Disposition: _____

61. Signature of Final Resting Place: _____

62. Signature of Final Disposition: _____

63. Signature of Final Resting Place: _____

64. Signature of Final Disposition: _____

65. Signature of Final Resting Place: _____

66. Signature of Final Disposition: _____

67. Signature of Final Resting Place: _____

68. Signature of Final Disposition: _____

69. Signature of Final Resting Place: _____

70. Signature of Final Disposition: _____

71. Signature of Final Resting Place: _____

72. Signature of Final Disposition: _____

73. Signature of Final Resting Place: _____

74. Signature of Final Disposition: _____

75. Signature of Final Resting Place: _____

76. Signature of Final Disposition: _____

77. Signature of Final Resting Place: _____

78. Signature of Final Disposition: _____

79. Signature of Final Resting Place: _____

80. Signature of Final Disposition: _____

81. Signature of Final Resting Place: _____

82. Signature of Final Disposition: _____

83. Signature of Final Resting Place: _____

84. Signature of Final Disposition: _____

85. Signature of Final Resting Place: _____

86. Signature of Final Disposition: _____

87. Signature of Final Resting Place: _____

88. Signature of Final Disposition: _____

89. Signature of Final Resting Place: _____

90. Signature of Final Disposition: _____

91. Signature of Final Resting Place: _____

92. Signature of Final Disposition: _____

93. Signature of Final Resting Place: _____

94. Signature of Final Disposition: _____

95. Signature of Final Resting Place: _____

96. Signature of Final Disposition: _____

97. Signature of Final Resting Place: _____

98. Signature of Final Disposition: _____

99. Signature of Final Resting Place: _____

100. Signature of Final Disposition: _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9519

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09493

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queen Anne</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R 710 # 1</u>				d. STREET ADDRESS <u>1 R 710 # 1</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HOWARD ROSS MCDADE</u>				4. DATE OF DEATH Month Day Year <u>Aug 12 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 16 1878</u>	
9. AGE (In years last birthday) yrs. <u>80</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		11. BIRTHPLACE (State or foreign country) <u>Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James F. Mc Dade</u>				14. MOTHER'S MAIDEN NAME <u>Wilhelmina Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no (or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>Marie Jackson-Queen Anne</u> Address <u>Queen Anne</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Encephalomyelitis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>chronic</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery disease</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 15 1959</u> to <u>Aug 12 1959</u> , that I last saw the deceased alive on <u>Aug 3 1959</u> , and that death occurred at <u>1:50</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kurt Lederer</u>				ADDRESS (Street, city or town, state) <u>Queen Anne Md</u>			
PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>				DATE SIGNED <u>8-13</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sawoncroft</u>		22d. LOCATION (City, town, or county) (State) <u>Linwood Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. Marvel, Shays Station</u>				ADDRESS <u>Shays Station</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 14 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

0.750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/58

9520

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09494

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Q.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>		c. LENGTH OF STAY IN 1b <u>5 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>—</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Katherine Elizabeth</u> Middle <u>Reese</u> Last <u>Reese</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 24-1893</u>		9. AGE (In years last birthday) <u>66</u> yrs.	10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md. Baltimore Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Dietrich</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Link</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT <u>Henry Reese</u>		Address <u>Queenstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> <u>543X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Acute Gastritis</u> (c) <u>—</u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>1 hrs.</u> <u>24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>—</u> <u>—</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u> <u>—</u> <u>—</u>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>55</u> , to <u>Aug</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Aug. 15</u> , 19 <u>59</u> , and that death occurred at <u>8:45</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Queenstown, Md.</u> DATE SIGNED <u>8/16/59</u> ACTUAL SIGNATURE <u>Irwin H. Hoyt</u> M.D. PHYSICIAN'S NAME (Type) <u>Irwin G. Hoyt</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Chestersfield</u>		22d. LOCATION (City, town, or county) (State) <u>Centerville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Baiter, Baiter Bros. Centerville Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: For this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9521

CERTIFICATE OF DEATH

03495

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Queen Anne</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD Chestertown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X RFD from Chestertown Post Office</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>At Home</u>		d. STREET ADDRESS <u>RFD</u>	
3. NAME OF DECEASED (Type or print) <u>J. Earl Smith</u>		4. DATE OF DEATH Month <u>Aug. 1,</u> Day <u>1959</u> Year <u>19</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 24, 1900</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ret. owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Queen Anne Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>J. Thomas Smith</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Walls</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-36-1005</u>	
17. INFORMANT <u>Mrs. J. Earl Smith</u>		Address <u>Chestertown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma, Left Lung</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>0 year</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/1</u> , 19 <u>58</u> , to <u>8-1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>8-1-59</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>8/2/59</u>			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert W. Farr</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Chestertown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. L. Wells</u>		ADDRESS <u>Chestertown, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hous</u>	

CERTIFICATE OF DEATH

1921

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		45		M		W		1876		BALTIMORE		BALTIMORE		BALTIMORE		MD	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE	
Carpenter		High School		Married		Roman Catholic		1921		BALTIMORE		BALTIMORE		BALTIMORE		MD	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVAILING DISEASE		DATE OF ONSET		DATE OF DEATH		CITY		COUNTY		STATE	
Heart Failure		Natural		3 weeks		Coronary Artery Disease		1921		1921		BALTIMORE		BALTIMORE		MD	
SIGNATURE OF PHYSICIAN		DATE		SIGNATURE OF WITNESS		DATE		SIGNATURE OF DECEASED		DATE		CITY		COUNTY		STATE	
J. H. HARRIS		1921		J. H. HARRIS		1921		J. H. HARRIS		1921		BALTIMORE		BALTIMORE		MD	

RECEIVED
BALTIMORE
MAY 1921

9522

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY QUEEN ANNE'S		2. USUAL RESIDENCE (If deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY QUEEN ANNE'S	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chester		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Walton Weldon Thompson		4. DATE OF DEATH Month AUG Day 24 Year 1959	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 30 1916 9. AGE (In years last birthday) 42 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Alonso		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) GRANOVILLE, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward S. Thompson		14. MOTHER'S MAIDEN NAME Mary E. Tarr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go. or unknown) YES (If yes, give war or dates of service) WW II		16. SOCIAL SECURITY NO. 270-01-8527	
17. INFORMANT Address Orem A. Thompson, Chester, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Edema 581.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Delirium Tremens DUE TO (c) Liver Contraction (Acute)		INTERVAL BETWEEN ONSET AND DEATH 8:19-59 P P 24 59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-19 , 19 59 , to 8-23 , 19 59 , that I last saw the deceased alive on 8-23 , 19 59 , and that death occurred at 2:30 M, from the causes and on the date stated above. 8-24-59 ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Luigi Baldi MD M.D.			
PHYSICIAN'S NAME (Type) LUIGI BALDI MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 27-59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington Va	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS William Beatty Patton Bros Centerville Maryland		24a. REC'D BY REGISTRAR DATE AUG 31 59	
24b. REGISTRAR'S SIGNATURE Arthur & Thoma			

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

9582

[Faint, mirrored text from the reverse side of the page is visible through the paper. Legible fragments include:]

NAME: *[illegible]*
AGE: *[illegible]*
SEX: *[illegible]*
DATE OF BIRTH: *[illegible]*
PLACE OF BIRTH: *[illegible]*
OCCUPATION: *[illegible]*
CAUSE OF DEATH: *[illegible]*
MANNER OF DEATH: *[illegible]*
DATE OF DEATH: *[illegible]*
PLACE OF DEATH: *[illegible]*
SIGNATURE: *[illegible]*
DATE: *[illegible]*

1